SECTION V.10. Enrollment & Billing Procedures

A. Provider Enrollment

All Choices for Care (CFC) providers must enroll as a CFC provider in the Medicaid claims processing system via HP Enterprise Services (HP). The following procedures shall be used to enroll CFC service providers:

1. The interested agency or organization must contact the Department of Disabilities, Aging and Independent Living (DAIL) CFC administration to request DAIL authorization to provide specific CFC services. The interested provider must provide the following information to DAIL in writing:
    - The name of the provider agency or organization
    - The address, phone number, and fax number of the agency or organization
    - Contact person in the agency or organization (for purposes of discussing provider eligibility and provider enrollment)
    - Verification of of applicable licensure or certification (in good standing) required for the CFC provider type
    - Requested effective date of Medicaid Waiver provider status
    - The service(s) which the agency or organization would like to provide
    - Other documentation as requested

2. DAIL may contact the agency or organization to request additional information, and may visit the agency or organization prior to approving or denying the request.

3. If DAIL denies the request, DAIL will communicate this in writing to the organization.

4. If DAIL authorizes the request, DAIL will send an enrollment request to HP verifying that DAIL has authorized enrollment as a CFC Medicaid provider.

5. The CFC provider will obtain a copy of all the applicable sections of the CFC Manual, brochure and Referral forms (when applicable).

6. The CFC provider must contact HP provider enrollment (802) 878-7871 or 1-800-925-1706 (toll free if you are calling in Vermont) or go to http://www.vtmedicaid.com/Downloads/forms.html and complete a Vermont Medicaid provider enrollment form. The form must be fully completed by the authorized provider and submitted to HP.

6. HP Provider Enrollment and Recertification staff will assure that the provider has completed a Medicaid provider enrollment agreement, assign a provider number and confirm the provider's enrollment in writing to the provider.

7. Any problems or obstacles in provider enrollment will be addressed by negotiation between HP, DAIL, and the potential service provider.

B. Claims

1. CFC service providers shall only submit claims for Medicaid reimbursement for services that have been provided to eligible participants in compliance with applicable service definitions, provider qualifications, and standards.

2. CFC service providers shall submit all claims for CFC services through Vermont's Medicaid Management Information System (MMIS), managed by Vermont's Medicaid fiscal intermediary, HP Enterprise Services (HP), in accordance with HP procedures. Questions about CFC service claims, payments, and claims procedures should be addressed to HP (802-879-4450) or found at http://www.vtmedicaid.com/Downloads/forms.html.

3. CFC service providers shall have mechanisms or procedures to assure that claims which are submitted are accurate, and in compliance with all applicable CFC procedures and regulations.

4. CFC service providers are responsible for preparing and submitting claims for services that they provide or are designated to manage no later than six months following the date of service.

5. Adult Family Care (revenue code 086) services and billing is managed by a DAIL approved "Authorized Agency" who manages and pays for the services provided within the DAIL authorized Tier Rate.
   a. The Authorized Agency maintains 5% of the Tier Rate for administrative fees.
   b. The Authorized Agency may bill up to 30 days at 94% of the Tier Rate while the participant is admitted to a hospital, for the purpose of providing services needed to the participant during an inpatient hospitalization stay. An inpatient hospitalization day is a day in which the participant is an admitted patient at the hospital and is still there at midnight. For example: If a person is admitted to the hospital at 10 a.m. on June 7th and they return home at 1 p.m. on June 10th, the Authorized Agency may bill up to 94% of the Tier Rate for dates of service June 7th, 8th and 9th. The Authorized Agency may bill 100% of the Tier Rate on June 10th. *Reference Adult Family Care Section IV.11 for details.*

6. Participant-Directed and Surrogate-Directed Services (revenue codes 071, 075, 077, 080, 081) are provided by workers employed by the Participant or surrogate employer. Services shall be billed through an intermediary service organization (ISO) which is a payroll agent for Participant employers and surrogate employers.

7. Home-Based Waiver Assistive Devices and Modifications (revenue code 076) services may be provided by a variety of organizations or individuals. Services shall be billed through the individual's case management agency. When needed, items may be purchased and claims paid prior to discharge from a nursing home, as long as there is an active discharge plan in place.

   The following billing dates are to be used:
   a. Assistive Devices: The billing date (date of service) will always be the date the item was received by the individual.
   b. Home Modifications: The billing date (date of service) will always be the date the home

modification work was completed.

c. Loans/Payment plans: The billing date (date of service) will always be the date the payment is made to the service provider as part of a payment plan established by the case manager in advance.

8. CFC service providers shall submit claims using the correct revenue code, as listed in the DAIL Rate Table.

9. The Service Plan must be approved by DAIL and received by the service provider before any claims for CFC services may be submitted to the HP Medicaid claims processing system. Providers enrolled in using SAMS may utilize the SAMS Care Plan tool as DAIL authorization.

10. CFC service providers must obtain and retain copies of the approved Service Plan for every waiver participant to whom waiver services are provided. The approved Service Plan specifies the type, frequency and volume of CFC services, as well as the start date and end date of approval. Only claims for services that comply with the details and limitations of the approved Service Plan may be submitted to the Medicaid claims processing system.

11. **DAIL** will consider retroactive requests for Service Plan increases (HB & ERC) only under certain circumstances when a precipitating event necessitates an immediate increase of services exceeding the currently approved volume of services.
    a. The immediate increase must be necessary to prevent harm to the individual, a hospitalization or nursing home placement. For example: The home-based primary caregiver is hospitalized or the individual has a medical event that requires immediate increase in services.
    b. Retroactive Service Plan changes will not be approved to cover administrative errors or non-emergent requests for increases.
    c. All requests for retroactive coverage must accompany a Service Plan change, a written request for a specific start date and a description of the precipitating event.
    d. The effective date of the change or changes shall be no greater than six months proceeding the date that the request is received by DAIL.

12. If a CFC service provider submits any claims for any waiver services that exceed the dates, types and/or amounts of services that are authorized by an approved Service Plan, the service provider must arrange recoupment (or re-payment) to HP of all payments for services that exceed the dates, types and/or amounts authorized.

13. If a CFC service provider submits any claims for any waiver services which exceed the types and amounts of services actually provided to an eligible individual (but are within the dates, types and amounts of services which are authorized by an approved Plan of Care), the service provider must arrange recoupment (or re-payment) to HP of all payments for services which exceed the amount actually provided.

14. Case Management services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing home or hospital, when such services are clearly documented as facilitating the individual's return to the community.

15. Case Management services claims that exceed the billing cap of 48 hours per calendar per person must be submitted with a copy of the applicable DAIL variance approval letter.

16. Enhanced Residential Care (ERC) and Assistive Community Care Services (ACCS) shall submit claims for days the participant in the in home. This is determined by where the participant is at midnight on the date of service. A date of service = 12:01am-12:00am (midnight). For example: If a person is admitted at 1 p.m. to the hospital on 6/10/13 and returns to the home at 10 a.m. 6/12/13, the home shall not submit an ERC or ACCS claim for 6/10/13 and 6/11/13. However, the home will submit a claim for the day before admission (6/9/13) and the date the person returns to the home (6/12/13).

17. Hourly services must be rounded to the nearest 15-minute billing unit for all approved activities provided on the same date of service.

    Example #1: If case management services provided to a person on 6/20/13 included 40 minute round-trip drive to the participant's home, 45 minute home visit, and 3 minute review and response to an email from a provider, the total minutes for that day equals 88 minutes, which rounds to 1.5 hours or six (6) 15-minute billing units.
    Example #2: If case management services provided to the same person on 7/1/13 included a 5 minute phone call, a 2 minute email and a 1 minute phone message the total billable time for 7/1/13 is 8 minutes, or one (1) 15-minute billing unit.
    Example #3: If a home health personal care attendant provided 2.5 hours (150 minutes) of personal care in the morning and a second attendant provides 3 hours and 25 minutes (205 minutes) in the afternoon to the same person. The total rounded billable time for that person on that date of service is 6 hours or 24 billing units.

C. Medicaid Fraud & Abuse

The Department of Vermont Health Access (DVHA) Program Integrity (PI) Unit strives to ensure that Medicaid funds are utilized appropriately through the identification and reduction of Medicaid fraud, waste and abuse. Quality control measures designed to help control rising costs of health care and protect diminishing state resources help protect the integrity of Vermont's Medicaid program through the elimination of beneficiary and provider fraud, waste and abuse. For more information or to report suspected healthcare fraud or abuse, go to http://dvha.vermont.gov/for-providers, call (802) 879-5900 or email ReportMedicaidFraud@state.vt.us.

D. Revenue Codes and Rates

As of July 2008, all Choices for Care billing revenue codes and rates are maintained and located in the **"DAIL/DDAS Services: Medicaid Claims Codes and Reimbursement Rates"** table. The table is found on the DAIL website under Choices for Care Publications and Reports at http://www.ddas.vermont.gov/ddas-publications/publications-ddas/publications-ddas-default-page.

E. Claims Resolutions

Medicaid providers must take the following steps to resolve any unpaid Medicaid claims.

1. Verify the participant's health care eligibility using one of the HP verification systems. See the HP provider billing manual for instructions or go to www.vtmedicaid.com. Eligibility must be verified before providing services or submitting claims. Do not submit claims if eligibility has not been verified as approved.

2. For long-term care **Choices for Care** (CFC) claims – Verify that the CFC setting matches the service being provided for date of service you are billing for. You can do this through the HP Help Desk/Malcolm voice response system: **In-state at 1-800-925-1706** or **out-of-state at 1-802-878-7871** ***Be sure to listen to the entire Malcolm message.***

3. If the Medicaid provider finds that there is no current CFC eligibility, services should not be provided or the Medicaid provider must provide written notification to the individual advising them they will be responsible to pay for the services if determined not eligible.

4. Before calling HP or any state office about a denied claim, providers have the following information ready:
    a. Name and date of birth of individual
    b. Social Security number
    c. Date claim submitted
    d. Remittance Advice (RA), Description of reason for claim denied on the RA (located on the last page), not just the denied number
    e. Type and date of service, e.g. case management for 12/3/12

5. If the provider has verified eligibility but the claim is denied for other reasons contact the HP help desk.

    HP Help Desk in-state at 1-800-925 –1706
    Or
    HP Help Desk out-of-state at 1-802-878-7871

    VT Medicaid Portal: http://www.vtmedicaid.com/index.html